

COMMUNICATION RELEASE FORM

Documentation Regarding Patient's Agreement of Objection to Disclosures to Persons Involved in the Care

Patient Name: _____ **Date of Birth:** _____

I hereby give permission to JCH Medical Group to notify me by telephone of the following: (Check all that apply)

Yes No Appointment reminder, either by personal or recorded message

Yes No A message to call the office for test results

Note: At no time will actual test results be left by message!

The following individuals are involved in my care or payment for my care and may disclose Protected Health Information (PHI) to these individuals as necessary for their involvement in my care:

Spouse / Significant Other: _____
Name Telephone

Family Member & Others	Name	Telephone
	Name	Telephone
	Name	Telephone

Primary Care Physician & Other Physicians Or Counselors	Name	Telephone
	Name	Telephone
	Name	Telephone

(For the purpose of Coordinating Care)

Acknowledgement

I understand this form is intended to guard my privacy and is **NOT** a release of general medical information. I fully understand and **ACCEPT** the terms of this consent.

(Signature)

(Date)

(Witness)

(Date)